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BULLETIN of the
MENNINGER CLINIC

VOLUME 14 JANUARY, 1950 NUMBER 1

THE RELATIONSHIP OF CLINICAL PSYCHOLOGY AND PSYCHIATRY*

By WILLIAM C. MENNINGER, M.D.

It is with a sense of very special responsibility that I accept this signal honor that you bestowed upon me in extending the invitation to discuss the relationship of clinical psychology and psychiatry. I want to commend your Program Committee for a plan which permits those of us in related fields to discuss with each other our different points of view.

I am quite sure that I was not invited merely to present platitudes about our relationships nor to offer bouquets to a sister profession. Neither is it my intention to attempt a critical evaluation of the field of clinical psychology. This I feel would be presumptuous. I do wish to discuss the interrelations of psychiatry and clinical psychology.

To see ourselves as others see us—no matter what they see—should be helpful. In 1894 The American Psychiatric Association at its fiftieth anniversary meeting invited the famous neurologist, Dr. S. Weir Mitchell, to give an evaluation of the Association.[1] His remarks were almost caustic and disturbed the complacency of the membership for some years. In 1944, at the 100th anniversary meeting, Dr. Alan Gregg was invited to give a critique of psychiatry.[2] In forceful language he told the psychiatrists that they were badly recruited, isolated from medicine, too inarticulate and long suffering.

My hope is that my remarks may be interpreted in the light of my avowed respect for the place of psychology in the practice of psychiatry, plus my very satisfying personal experiences in working closely with clinical psychologists. Many of you know of our struggle in the army during the war to persuade the Adjutant General that the clinical psychologists who were in his department since World War I belonged in the medical department.[3] It is my often reiterated opinion that clinical psychology is essential to the best practice of psychiatry.[4] The integrated relationship of team experience of clinical psychologists and psychiatrists in Topeka is a matter of pride

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to both professional groups. The attitude of the psychiatrists in that team was well expressed by my brother when he said that "the diagnostic function of the psychologist is now so well established in psychiatry that the competent psychiatrist would no more exclude the special techniques of the psychologist in his diagnostic studies than would a capable internist routinely exclude the findings of the roentgenologist."[5]

A part of the special responsibility I feel is the real expectation that, as a psychiatrist, I will of necessity represent psychiatry. There should be no illusions, however, that I am speaking officially for psychiatrists because of my recent official responsibilities in psychiatric organizations. I can speak only for myself, although I believe that many of our leading psychiatrists would agree with most of the opinions which I express. In July, many of you received the report[6] of the Committee on Clinical Psychology of The Group for the Advancement of Psychiatry, a collective opinion regarding professional relationships as formulated by psychiatrists but with the guidance of some of your own members. That document does represent the consensus of at least 100 psychiatrists but for many reasons does not touch on certain points which I wish to discuss here.

Clinical psychology and psychiatry are engaged in a mutually cooperative enterprise, an association that has developed within our own generation. It is to be expected that there would be some areas of misunderstanding, even some of disagreement. It is our mutual obligation, however, to clarify these with the greatest possible speed since our job is not concerned with academic disputes but with the health and welfare of people. In order that we may give patients the maximum benefit of our combined skills, it is incumbent upon us to work out our own inter-personal and working relations as rapidly as possible.

We are told reassuringly that many of these misunderstandings are ghosts. A survey[7] has indicated that at local levels, there is generally a harmonious relationship. This, however, does not necessarily mean that the existing relationship is the best one. Furthermore, in many situations the appearance of harmony may be due to the fact that there is no overt resentment or hostility. We cannot minimize the evidences of both ignorance and criticism within each group concerning the other which in turn give rise to varying degrees of insecurity and even fears.

During my war experience I did do battle in order that the psychiatrists and the clinical psychologists might work together. It was something of a surprise to me to learn that a large percentage of physicians practicing psychiatry had never been associated with a clinical psychologist and, similarly, that many of the individuals classified as clinical psychologists had never worked in a medical setting. I have no doubt that the war experi-

ence was a major impetus toward bringing our professions closer together. Many of us have strong convictions based on personal experience that our association together is essential and that our relationships can be effective and satisfying. On the other hand, many clinical psychologists and many psychiatrists have not had such a relationship and, therefore, lack such convictions.

Since many of my remarks will of necessity relate to the attitude of the psychiatrist toward the clinical psychologist, it might be well to indicate some of my insight into the psychologist's attitude toward the psychiatrist. In both instances, may I remind you that my remarks will express the opinions or the evaluations of only some clinical psychologists and some psychiatrists. In both cases they are far from being unanimous opinions. Such attitudes are based on individual experiences and therefore are always strictly personal. We must accept the fact, however, that they do represent the feelings that exist in some of the members of each group towards the other.

Not infrequently the psychologist at a case conference has good reason to believe that the psychiatrist is pontificating, tending to brush aside any contribution made by others than psychiatrists. The narcissistic injury to the psychologist is increased by the fact that he knows that even the most opinionated psychiatrist usually does accept the findings of the roentgenologist or of the clinical pathological laboratory. Such a situation may represent an inadequate respect for the psychological test findings on the part of the psychiatrist. It may represent the assumption that only psychiatrists have a right to an opinion on a case, whether or not the opinion is based on test findings.

A common complaint is that some psychiatrists substitute "experience" for evidence and make the misunderstanding worse by appearing to have an uncritical attitude towards their own work, confusing opinions and theories with facts. Such confusion may be clearly evident to the research trained psychologist.

Psychologists believe that they should decide upon the various tests to be applied in a specific case study and that the psychiatrist is out of step and usurping the judgment of the psychologist when he, the psychiatrist, asks that a specific test be given. The psychologist, like the psychiatrist, is inclined to guard his domain jealously and, as a consequence, such a request is interpreted as the psychiatrist's bad judgment or ignorance in crossing the boundaries of another profession. In the area of treatment, one occasionally hears the argument that psychiatrists ignore the fact that the general practitioner in medicine practices psychotherapy with little or no competence and yet strongly opposes the psychologist entering that realm.

Background of Similarities and Dissimilarities

Having expressed the criticism of some psychologists towards some psychiatrists, my subsequent remarks will deal with the attitude of the psychiatrist toward the psychologist. In so doing I shall return to discuss some of these points just mentioned. Before considering the current relationships between clinical psychology and psychiatry, it might be well to examine the perspectives of these two professions as to their similarities and dissimilarities.

Discussion can be confusing because as yet there are various semantic interpretations of the word "clinical."[8] In medicine, the term "clinical" refers to the diagnosis and treatment of sick people. The first usage of the term "clinical psychology," coined by Witmer in 1896, referred to work in a psychological clinic for the treatment of all classes of children suffering from retardation or physical defects interfering with school progress.[9] The term is still in common usage to apply to the work in personnel selection, vocational guidance and other fields. Strenuous efforts are being made to clarify this confusion and the considerations of the special committee of the American Psychological Association deal strictly with the concept of the clinical psychologist as one who works with seriously maladjusted people. Until the accreditation program of the psychologists has had time to become effective, both groups will be harrassed with the recurring question: "Who is a clinical psychologist?"

Among the similarities, clinical psychology together with psychiatry is deeply concerned with the problems of mental health. This subject has rather suddenly risen to a position of great importance in the mind of the public. Undoubtedly the war experience was responsible for this to a large degree and as a result the spotlight is focused on these two disciplines. The stresses and trauma related to the war, involving such vast numbers of people over most of the world, were responsible for personality deviations of a degree and type that occurred only endemically, or to a minor extent, during the previous period of peace. The experts, who for the most part had both to deal with and to explain these reactions, were the psychiatrists, psychologists and psychiatric social workers. None of these professions was prepared adequately to meet this emergency, with the result that the spotlight of the war has shown up some of our weaknesses.

In both psychology and psychiatry we need far greater knowledge. Both professions are extremely short of personnel. The current demands for service are far beyond our ability to meet them. As a result we are both in what Rapaport[10] called a "seller's market" which seriously threatens our professional idealism and presents the danger of a mushroom growth of quacks and incompetents in our fields.

Psychiatry and clinical psychology have the common problem that a considerable number of individuals without adequate training or qualifications are working in these fields. They present themselves to the unknowing public as members of our professions. Clinical psychology is in a worse situation than psychiatry because the persons practicing psychiatry are at least graduate physicians; by comparison, some of the individuals purporting to be clinical psychologists do not hold even a master's degree. The public, unfortunately, judges us by what we call ourselves, i. e., psychiatrists and clinical psychologists, rather than by investigating our qualifications and training.

Another similarity—which is at the same time a great advantage and a handicap—is that both our professions are comparatively recent offshoots of large and very old professions. The result in both cases has been the somewhat skeptical attitude by the major profession of which they are a part. Both our specialties are a long way from being fully accepted by their parent bodies and in some limited areas they are even rejected. Therefore, both clinical psychologists and psychiatrists must currently devote no small amount of effort to interpreting themselves, and making helpful contributions to the much larger fields of psychology and medicine in order that they may gain the desired full acceptance.

Finally, both psychiatry and clinical psychology, perhaps because of the urgency resulting from their comparatively late start, have made enormous gains in knowledge within their fields in a very few years. Both have developed many new techniques and approaches with a resulting accumulation of wider understanding, increasing areas of application and positive results. Nevertheless it requires time for the acceptance and wide application of this knowledge.

There are some major dissimilarities between clinical psychology and psychiatry. Clinical psychology has the advantages as well as the handicaps of youth, so ably presented to you by Doctor Gregg last year. The great advantage, as he pointed out, is its still current freedom "to chart its course, make its promises and find its friends."[11] By contrast, psychiatry, being somewhat older, already has charted its course; for that reason, it has much to unlearn or relearn; before the last war it perhaps had more enemies than friends.

Psychology, because it is relatively new in the clinical field, has as yet had only limited opportunity both in the area of training and experience to develop a widely accepted and thus uniform system of practice and ethics toward fellow workers and patients. In contrast, psychiatry has long been a part of a profession which has developed and crystallized a close relationship among its practitioners, and a code of ethics concerned with the care of the patient. Clinical psychology arose from a background of

testing, investigation and an experimental approach; psychiatry from a background of humanics, public service, close inter-personal relationships with suffering people, and an almost entirely clinical approach.

Consideration of these dissimilarities throws light on some of the difficulties in the current relationships between clinical psychology and psychiatry. Clinical psychology is still in the position of struggling for recognition and status.

In the clinical field, a major obstacle relative to its acceptance, is the fact that physicians always have had and will continue to have the major responsibility for defending people against disease and protecting them against death. Because of this responsibility, the public attributes to physicians the magic qualities of omnipotence and omniscience. There is no experience in either the training or the practice of clinical psychology which can provide some of the disciplinary effects of medical practice: knowing that one has done something that cost a life or failed to do something that would have saved a life; and on the other hand, experiencing the emotional satisfaction when one has been able to do something that brought the near-dead back to the world of the living.

There is another comparative difference in the training of psychiatrists and clinical psychologists which sometimes is either ignored or forgotten. This has to do with the length of the training period. Psychiatric training has become almost entirely a post-doctoral training. This means a minimum of 12 years from the time a man enters college until he has finished his residency training in psychiatry. By contrast, the doctorate of philosophy in clinical psychology requires 8 years in training which equips an individual reasonably well to carry on his work.

The point is sometimes made that much of the medical training of the psychiatrist is not necessary for the work that he performs. This question is not so much a specific problem to psychiatry as it is to the reorganization of medical education. The ophthalmologist has no greater need to know the details of the articular facets of the carpal bones than does the psychiatrist. There is no question, however, that the great majority of psychiatrists believe a full medical background is essential to their job of diagnosis and treatment. This question is theoretical since the realistic fact is that currently the full four years of general medical training *is* the accepted and required program. Were there to evolve a shorter course for the psychiatrist without a general reorganization of all medical education, the medical profession would be even less likely to accept psychiatry than is now the case.

With this background, it may be helpful to discuss, quite frankly and freely, some of the details in the relationship between psychiatry and clinical psychology in the four major areas of their work, namely, training, diagnosis, therapy and research.

Training

The average psychiatrist has had little opportunity to become acquainted with the courses in the curriculum or the training plan in clinical psychology. Probably the average clinical psychologist, knows as little about the curriculum and training of the psychiatrist. This ignorance of each group regarding the training of the other is in itself a source of some misunderstanding. Because the psychiatrist-physician grows up in a clinical atmosphere through his last two years in medical school and his year or two of internship, it is understandable that some should feel that the psychologist needs more than a year of experience with emotionally ill people in order to be a clinician. One may hope that the training of the clinical psychologist will become more therapeutically permeated and that the latter part of the program will include more clinical experience.

It is significant that a considerable number of the leaders in the educational program of clinical psychology have come directly to this meeting from a conference concerned with this all important problem of training. Many of us will be deeply interested in their thinking and conclusions. Several times I have expressed myself strongly to the effect that if we are to develop team work, it can be done effectively only if the training of both the psychiatrist and the clinical psychologist can take place in parallel situations. It has always seemed an elementary requisite to me that the post-doctoral training of the physician in psychiatry and a considerable portion of the doctoral training of the clinical psychologist should be given in the same setting. Bringing the members of the team together in this, their training period, would provide an opportunity to learn to work together.

Such a program of joint training would reinforce the current trend for psychiatrists to be involved in the training of clinical psychologists, and in turn for clinical psychologists to be involved in the training of psychiatrists. Such a plan does not imply equal responsibilities in the training but it does give an early introduction to the members of both groups to the other discipline. It introduces the association between the two groups at a student level with both in the background of a clinical setting.

Diagnosis

Clinical psychology has made its major contribution to the practice of clinical psychiatry in the development and application of various personality tests. Their contribution has become essential to the best practice of psychiatry. Not all psychiatrists currently hold this opinion with me, although I believe that the majority do.

There are some areas of relationship in this diagnostic work that need further clarification and also a wider appreciation on the part of both

psychiatrists and clinical psychologists. Clinical psychology is as yet so young that it still has the job of mapping out its domain in relation to pre-existing professions. One must keep in mind that the average medical student who took some course in psychology in his pre-medical training in a university has little understanding and perhaps even misconceptions about clinical psychology. As the report of the Harvard Commission indicated,[12] anyone who regards "psychology in 1947 as the subject they studied in 1910 or 1915 or 1925 will seriously misunderstand most of this report." Furthermore, it is a common opinion among psychiatrists that to date the under-graduate studies in psychology have helped little or not at all in their preparation for medical practice. As a consequence, most psychiatrists who have not had the privilege of working with the clinical psychologist have little conception of what he can contribute through diagnostic testing.

Some psychiatrists who are aware of the trend of clinical psychologists to enter the field of therapy, ask the question: "If treatment does become the chief interest, who will do the psychological testing?" Such psychiatrists are not familiar with the opinion stated by Dr. David Shakow that most clinical psychologists do not regard therapy as their outstanding function.[13] The fact remains that some psychiatrists still express this concern.

A major obstacle to many psychiatrists in accurately evaluating the potential contribution of the clinical psychologist is the fact that most psychiatric institutions are greatly undermanned in their psychological staff. It is not infrequent that an institution with 15 or 20 psychiatrists has only one clinical psychologist. It should be obvious that under such circumstances the psychiatrist cannot possibly have any adequate knowledge of the potential contribution of the clinical psychologist.

Another factor that interferes with the best working relationships is due in part to ignorance and in part to tradition. I refer to the fact that the psychiatrist often has no first hand knowledge of the battery of tests available and utilized by the competent psychologist. This subject matter is never covered in medical school and as a consequence the average psychiatrist with minimal contact with clinical psychology, thinks only in terms of intelligence tests or perhaps the Rorschach Test. In the physician's training, he is taught to assume full responsibility for making a diagnosis of his patient's illness. In doing so, he often requests help from other associates, such as the clinical pathologist or the roentgenologist. In both instances, however, his medical training has taught him to request the specific tests that he wishes made. Every clinician knows that no laboratory procedure or psychological test can replace clinical evaluation or experience. As a consequence, some psychiatrists assume that it should be their responsibility to request a particular test of the clinical psychologist, failing to recognize that their own lack of knowledge in this field makes it impos-

sible for them to request the best help from the clinical psychologist. There is good reason to assume that even if the psychiatrist were better acquainted with the tests, the clinical psychologist by virtue of his training and experience with tests, plus a knowledge of the social and clinical history gained through team work, would be in the best position to select the tests.

As to the other side of this question: too often the clinical psychologist carries out his psychological tests almost in a vacuum as regards the rest of the team of which he is a member. From the early years of diagnostic testing at the Menninger Clinic until recently, psychological test studies were conceived and carried out as an autonomous procedure, concurrent with but independent from the clinical examination. Patients were referred routinely for a battery of psychological tests without knowledge on the part of the psychologist of the patient's problems other than a brief statement of the presenting symptoms. The test report then gave an "objectively" derived personality description, characterologic and psychiatric syndrome diagnosis.

The patient was usually tested by two or three psychologists, each giving one or more tests of the battery. Not infrequently it happened that the psychologist who ultimately analyzed the test results and wrote the report was one who had not tested that patient at all nor even seen him. Diagnostic testing and reporting were kept so strictly a "blind" procedure, that when a referring psychiatrist mentioned an interesting facet of the clinical picture or tried to discuss his impressions of the patient before the test report had been written, the psychologist raised a forbidding finger. He preferred not to be "contaminated" by fore-knowledge of the clinical material when writing his test interpretations. This caution about guarding the objectivity of the test findings had its origin in requirements of the research then in progress on the clinical validation of test patterns. The independently derived test results and clinical diagnosis were brought together in a staff conference where reconciliation was sought whenever differences occurred.

Even after diagnostic test patterns had in this way been amply validated,[14] the conception of the psychological test examination as a separate, objective diagnostic procedure continued to bound the psychologist's horizon of operation. Certain advantages were apparent, such as giving thoroughness to the total examination, serving as diagnostic insurance against clinical error, supporting the reliability of diagnostic findings by residents learning clinical methods, giving appraisal from another point of view, pointing up overt or subclinical pathology overlooked or insufficiently emphasized, etc.

We have since abandoned the "blind" approach, retaining it only as a teaching method in the training of new psychologists. We now have a closely coordinated "team" set-up consisting of a consultant staff psychiatrist,

resident psychiatrist, clinical psychologist, and psychiatric social worker. The psychologist participates from the very beginning, sometimes even before the patient's arrival, in the initial evaluation and intake process, helping to evaluate the nature of the problem and the best way to handle it. With other members of the team, he plans the course of examination, and is in touch with the progress of the patient throughout the work-up. Routine testing has given way to individual decision about the desirability of test study. The decision may be to give no tests, a full battery of tests, or certain specific tests to answer focal questions raised by the team. Under this procedure direct verbal communication is possible among all members of the team and findings may be reported informally at team planning or disposition conferences.

The method of presenting psychological data by some psychologists is a source of confusion and at times, even of irritation to the psychiatrists. Too often the psychological findings are reported in an over-technical manner and with a tone of finality. Too often there is a mechanical reporting of raw data without clear or sufficient interpretation. There are also instances in which there is an over-ambitious kind of reporting that attempts to go far beyond the evidence. All of us tend to develop a jargon, and certainly the psychiatrists have done this. This mistake, however, is shared by the clinical psychologists who have equaled their psychiatric confreres in developing semantic riddles. My impression is that the psychologist seems to understand the psychiatric jargon, but not infrequently the psychiatrist becomes mystified, perplexed and defensive in the face of the psychologist's jargon.

In concluding the remarks about the role of the clinical psychologist in diagnosis, I should like to express my opinion that clinical psychology has passed the "psychological laboratory" stage. Even twelve years ago, to have a psychological laboratory was indeed a progressive step in psychiatry. Today, the psychologist's contribution is much more than that of a laboratory report. Unlike the pathological laboratory technician, the clinical psychologist has no "tests" that give specific results in the way that vital organ and physiological functioning are measured, as for instance, by the electro-cardiograph, basic metabolic rate, sedimentation rate, or blood count. Neither does the clinical psychologist report raw test data, in the manner of the technician for ultimate interpretation by the clinician. The psychologist should be a clinician himself, since his findings have no absolute meaning in and of themselves. They attain significance only in light of the clinical interpretation of all of the findings in the patient's examination.

Today when, as a psychiatrist, I ask for a psychological test study of a patient, I do not particularly want to know the I.Q. or the Sum M to

Sum C Rorschach ratio. I expect to receive a diagnostic appraisal of a total personality, with discussion of the nature of the illness, character structure, strengths or weaknesses of ego defenses, characteristic modes of adaptation, likely course of the illness and amenability to treatment. True, that I have opinions about most, if not all, of these, myself, but I conceive of the psychologist's function as being to render an additional professional opinion which can hardly be fulfilled by merely requesting that he give some tests. This, it seems to me, is the difference between laboratory "prescription testing" and diagnostic consultation.

In too many instances, both clinical psychologists and psychiatrists, in their quest for scientific precision, seize upon tests and invest in them a certain cryptic aura of infallibility which in actuality they of course do not have. The fact is that tests simply serve as another mode of approach to the study of personality functioning and psychopathology. They are an observational and examinational means of extending the clinical study. The only significant question regarding the use of tests is "What can be learned about the patient through tests that cannot be obtained by the traditional interview and mental status examination?"

It is when the cross-sectional diagnostic test method enables us to learn anew or supplement our longitudinal historical knowledge of a patient that the psychologist assumes a unique part in the diagnostic process. The day is already here when psychological tests are recognized as clinical tools, not ends, and therefore referral to the psychologist should no longer be made merely for tests, but for a special kind of examination by a colleague to whom one looks for a consultation and professional opinion.

Treatment

Of the various areas of relationship between clinical psychology and psychiatry, the psychologist's role in treatment is in greatest need of clarification. The theoretical question posed by some psychiatrists is "Should the clinical psychologist do treatment?" I indicate that the question is theoretical because the fact is that many psychologists *are* treating patients. If he gives treatment, the questions are raised as to what type, under what circumstances, with what training?

That form of treatment referred to as *psychotherapy* is the crucial point at issue. Even this term is used loosely and most of us are familiar with the fact that the process called counselling very often becomes a form of psychotherapy. Theoretically, psychotherapy is indicated for the maladjusted or ill person; counselling is indicated for the healthy person who seeks advice about a specific problem, assumed to be minor in nature. Such a differentiation, however, becomes tenuous to many of us who think of marital problems, problems of parent-child relationships, speech handi-

caps, reading disabilities, educational maladjustment and many other human problems as having a very definite relationship to mental health.

Part of the misunderstanding arises from the fact that there is no sharp dividing line between intensive formal psychotherapeutic sessions with a severely neurotic patient on the one extreme and educational efforts with a child with reading difficulties on the other. Neither the average psychiatrist nor the average clinical psychologist is necessarily competent in some sub-specialist field, unless he has had special training and experience. Psychologists much more often than psychiatrists have specialized in vocational guidance, remedial reading and the other areas mentioned above. At the same time, there are many individuals who are competent in speech training or remedial reading who would not necessarily be claimed in the fold of the clinical psychologists.

A minor cause of misunderstanding illustrated by the extremes of a severe neurosis on the one hand and a reading disability on the other, is the assumption that the psychiatrist looks upon problems in human relations as disease and the psychologist looks upon them as problems of learning. I wish to affirm strongly the fact that psychiatrists are just as concerned with the subtle processes of learning as are psychologists. As was pointed out at the meeting of the committees of our two associations, the two professions must attack this joint area harmoniously.

Whether or not he practices formal psychotherapy, the clinical psychologist must be therapeutically minded. His examination in most, if not all cases, is a kind of therapy. *Any* contact with the patient has therapeutic implications. A clinical psychologist can function effectively only insofar as he has some recognition of the operation of unconscious mechanisms, inter-personal relations and symbolic meanings in a psychological examination. Because there are so many similarities in methods and purposes, I strongly urge that all psychologists whether they be teachers or investigators or clinicians, have an opportunity to develop a therapeutic attitude towards those with whom they work instead of one which is purely academic, didactic or experimental.

Our experience in Topeka with the clinical psychologist in the role of therapist has been very satisfactory. Several of our psychologists carry on intensive as well as brief psychotherapy, and they do so with the full confidence of our psychiatric staff. However, all of those carrying on treatment have periodic supervisory control hours with a senior psychiatrist. We are able to provide psychoanalytic training for a limited number of our staff psychologists, not for the purpose of developing them into psychoanalytic therapists but rather as a part of their total psychological training. Our members of both groups believe that our practice is in line with the progressive thinking expressed in the reports of the committees appointed

by this Association and by the American Psychiatric Association to study the inter-relations of psychiatry and clinical psychology.

As this audience probably knows, these committees have met separately and together. They have worked out at least a core of agreement regarding the psychologist's role in treatment, which has been reported to the official bodies of the two associations. The psychiatrists[15] expressed themselves as being opposed to the independent private practice of psychotherapy by clinical psychologists, although they do approve of their doing therapy in a medical setting. The committee from the American Psychological Association expressed the opinion[16] that all clinical psychologists engaged in diagnostic or therapeutic work "must maintain accurate, open channels for collaborative working relationships with physicians most qualified to deal with borderline problems which occur." They continue with the further statement that, "We are opposed to the practice of clinical psychology (and in particular to the practice of psychotherapy) that does not meet these conditions."

To many of us in both psychiatry and clinical psychology, the working relationship of our two committees and their conclusions, which so closely parallel each other, are indeed encouraging and reassuring.[17] The fact remains, however, that the committee of the American Psychiatric Association includes several psychiatrists who came into psychiatry following doctorate training in psychology. The committee of The American Psychological Association is made up chiefly of individuals who have had long and close working associations with psychiatrists. As a consequence, the findings and opinions of these committees are based on knowledge and experience that most of the members of our two professions do not have. I hope that all our membership will recognize the committee members as our leaders in this field and that those of us with any degree of influence in our respective professions will assume the responsibility for aiding these committees to present, explain and implement their conclusions.

If accepted, their recommendations will do much to clear a misunderstanding currently existing. As with most progressive steps, however, there is considerable emotional resistance to their acceptance. Resistance, by technical definition, is a method by which one avoids recognizing his unconscious motivation. It is a method of protecting the conscious ego from admitting unconscious and therefore irrational wishes. The resistances of a segment of the membership of each of our groups to an acceptance of the opinions of the other is worthy of a brief discussion.

What motivates a clinical psychologist to wish to be a psychotherapist? We do have the report that "the chief interest of a substantial proportion of the younger psychologists is to treat rather than to test or teach or investigate."[18] Although we have no accurate figures, undoubtedly a con-

siderable number of clinical psychologists are doing psychotherapy, even though this may not be the chief interest of the majority. Whether it is true or not, psychiatrists have the impression that an increasing number of clinical psychologists are becoming interested in this particular field of work. On the surface, the function of practicing psychotherapy is in sharp contrast with many features in the training of the clinical psychologist: precise quantitative measurement, correlation of concrete data, standardization of norms, statistical analysis of findings and other aspects of his work. Many of the younger psychologists apparently become interested in therapy before they have had their work in a clinic or hospital. Once having become associated with the field of clinical medicine, the psychologist becomes more cognizant that the basic purpose in relation to patients is curative rather than merely diagnostic. Therefore, it is understandable that upon seeing this new objective not provided for in his previous training, a new vista is opened that seems more attractive than merely collecting and studying data. Furthermore, his close contact with a physician leads to an identification with the physician. Some psychiatrists question whether these motives are justifiable in light of the current training program of the clinical psychologist.

The basic problem now confronting clinical psychology if it wishes to train psychotherapists is concerned with the curriculum of training. Even the best of the doctoral training programs provide only one full year of clinical work—in the medical sense.[19] Even though the committee on training in clinical psychology recommends that all four graduate years should provide contact with clinical material, this is not possible of fulfillment in the academic setting. Neither does the present curriculum provide any systematic training for psychotherapy in the sense of a psychiatric orientation.

Advisory counselling given by clergymen, teachers, lawyers, nurses, parents and others to their constituency is not psychotherapy. Psychotherapy, a formalized method to alleviate illness or maladjustment, requires an extensive training. It is not practical to try to separate maladjustment into major or minor types upon the assumption that the psychiatrist might provide the psychotherapy for the major illnesses and the psychologist for the minor illnesses.[20] Regardless of his membership in one profession or the other, if the chief function of the individual is to provide psychotherapy then he needs special training for this function.

Special training is not the only requirement for the psychotherapist who would provide competent treatment of a patient by psychotherapeutic means. Summarized by Knight,[21] these requirements include:

1. That he be thoroughly grounded in the basic science of dynamic psychology.

2. That he be well trained in clinical methods of evaluating the individual patient, not only in terms of general comparison with others presenting similar clinical pictures, but also in terms of the uniquely individual forces and factors in each individual patient.

3. That he then utilize, from among the available psychotherapeutic approaches and techniques, those particular ones which, according to his best clinical judgment, are most appropriate in a given case.

4. A fourth prerequisite does not follow logically from the previous argument, but is of an importance at least equal to the other three, that the psychotherapist be a person of integrity, objectivity, and sincere interest in people and that he be relatively free from personal conflicts, anxieties, biases, emotional blind spots, rigidities of manner, and settled convictions as to how people should properly behave.

From our experience in psychiatry, we have learned that many physicians who can do excellent clinical diagnostic work are not adept at prolonged or intensive psychotherapy. The probabilities are that in most instances the present educational curriculum in clinical psychology does not provide sufficient controlled experience to indicate clearly to an individual his own capabilities or limitations to carry on psychotherapy. Therefore, when the doctor of philosophy in clinical psychology, upon graduation sets himself up in private practice because of his interest in therapy, he has not had the experience or training which would permit him to recognize his own limitations. Nevertheless, many individuals do just this and for legal reasons call their attempted psychotherapy "counselling." Fortunately, the leaders in both of our professions fully disapprove of this practice. Unfortunately, a considerable number of individuals who classify themselves as clinical psychologists, maintain a resistance towards the acceptance of this opinion.

The resistance of the psychiatrist towards accepting the clinical psychologist as a therapist has many aspects. One rarely hears of any objection to the fact that the clinical psychologist is *the* competent person to handle various areas that are borderline to health such as speech training, remedial reading, educational counselling and personnel counselling. By training and experience, physicians are brought much closer to the vital aspects of health—birth, disease and death. As Jelliffe[22] said many years ago, "The physician, viewed as a functional unit in society, represents to the individuals in that society, that portion of themselves given over to the protection of their bodies from the forces of disease. . . . The patient's relation to the physician in the treatment . . . is a much more fundamental and human affair than most physicians realize . . . the physician is, from the unconscious point of view, constantly involved as a symbol to afford that sense

of security which in the unconscious is to exclude the fear of death—physical, financial, or social."

The physician senses this even if he cannot or does not verbalize it. His near-consecrated attitude is set forth in traditional codes of ethics, not only expressed in the Hippocratic Oath, but in a hundred ways, written and unwritten, that govern the manner in which he should relate himself to and conduct himself with his patients, his confreres and with the public. From the beginning, the medical profession assumed the major responsibility for community problems of health and disease. True it is, that until comparatively recently health and disease were viewed only in physical terms. Even so, those individuals with incapacity recognized as frank mental illness were consigned to the physician's care.

In assuming this responsibility for the problems of health and disease, the medical profession has fought and will continue to fight against quacks and imposters, exploiters and misguided do-gooders. It will continue to contest the unscientific claims of the health meddling fringe of chiropractors and neuropaths and many other cultists. It has taken a firm and determined stand against those who would capitalize on the credulity of people, whether this be through religious healing or cancer cures. There is little doubt that any audience could be more aware than this one of the fact that patients in mental ill health are currently subject to more opportunities for quackery than any other specialized field of medicine.

In this medical scene, psychiatry is a part. Psychiatrists proudly and rightfully proclaim that they were and are physicians before they became specialists. With this historical background it is more understandable why some psychiatrists are reluctant to accept a non-medical man assuming responsibility for treatment. There is some resistance to doing so even when such individuals are directly associated with physicians in practice. This attitude may be more pronounced in America than in European countries. For example, the American Psychoanalytic Association accepts for membership only those individuals who have the degree of Doctor of Medicine, despite the expressed attitude of Freud[23] approving of lay analysts or the custom of the European psychoanalytic societies to accept lay analysts.

It is one's personal privilege to agree or disagree with Freud's opinion. It is obvious that the American Psychoanalytic group does not accept it and feels that although Freud stated that medical knowledge or medical intervention is necessary in cases showing physical symptoms, he brushed aside the fact that many psychological symptoms have their origin in physical or chemical changes and that psychological conflicts often are expressed in physical symptoms. Furthermore, in many, many instances the differentiation of the origin of such symptoms is extremely difficult. Such a differentiation is not a prerequisite to treating many emotionally

distraught people but this is no argument for discarding such safeguards entirely. Not being an organically minded psychiatrist, I am convinced that many personality disorders do not have a chemical or physical etiology. On the other hand, the causative factor in most psychological illnesses is still unknown. One must remain open minded and in light of medical history, anticipate that extremely important findings bearing on etiology may be forthcoming from the pathologist, the chemist and the physiologist. The probabilities are that the physician will never accept any nonmedical individual who attempts to provide treatment for sick people without the safeguards provided through scientific medical knowledge.

Another doubt of some psychiatrists concerning the therapeutic activities of a psychologist is the unhappy potentialities that may arise from the association of the clinical psychologist with physicians other than the psychiatrist.[24] This is not entirely a "dog-in-the-manger" attitude. They know only too well that many physicians, as well as laymen, simply do not have sufficient knowledge to distinguish between a psychiatrist and a psychologist. In any relationship with a physician who makes no such distinction, the psychologist is almost surely to be tempted to overstep his limitations.

Surely this audience is aware of the fact that medical education has long ignored or dealt inadequately with training in psychiatry. Even at this present date some of our medical schools still provide only a meager 30 hours of instruction in psychiatry in the entire four year curriculum. A fair percentage of the present generation of physicians who graduated ten years or more ago have very little knowledge of psychiatry and many still think of it only in terms of psychoses. The fear of the psychiatrist is therefore that such a physician would misuse the clinical psychologist or at least place the latter in the embarrassing position of being expected to apply skills which he does not possess. Where the psychologist's role, both by assignment and practice, is one of personality testing, such fears are unwarranted. In fact, many of us in psychiatry take pride in the wider utilization of the clinical psychologist in the general field of medicine.

The improvement in difficult inter-relationships between psychiatry and clinical psychology must depend on numerous factors. It will depend on the acceptance of the fact by clinical psychologists that certain kinds of painstakingly gathered clinical knowledge, usually referred to as "dynamic psychiatry," are prerequisites to carrying on psychotherapy. The eventual solution will also depend upon the establishment of improved training methods in clinical psychology, and upon the recognition that training in psychotherapy is a tedious, slow and primarily post-doctoral experience. Those who venture in this direction will also have to accept the fact that in the current scene, and for some time to come psychiatrists will have to

be their chief teachers. I suspect the situation will have to evolve to a point where the psychologist can accept the psychiatrist as the quarterback of a team that works together, in which neither individual need be concerned with threats from the other. We must reach a stage in our evolution when the bugaboos of status, jurisdiction, equality and subordination become dead issues.

Research

The fourth general area in which psychiatry and clinical psychology are related is research. Historically, it is here that clinical psychology has made its greatest contribution to psychiatry. Furthermore, the training of the clinical psychologist provides an introduction into investigative techniques and the experimental method while the great majority of psychiatrists have had no such opportunity. Sometimes it is assumed that because of this training, all clinical psychologists should carry out some research project as a part of their regular work. From my limited point of view, this always seemed fallacious since I cannot accept the premise that all individuals who have clinical abilities would necessarily have the rarer abilities of a productive research worker. On the other hand, it is extremely important that all individuals—psychologists and psychiatrists—who have the interest in and ability to do research should be afforded the opportunity to engage in it.

The great interest and activity in research on the part of the psychologist, coming as he does from the academic background, is the source of some misunderstanding and sometimes ill feeling on the part of the psychiatrist. Regardless of whether they have the capacity for research, many physicians would idealistically like to carry on research projects, and many do. With the current demand for psychiatric service, however, it is the rare psychiatrist who has any consistent allotment of time to devote to research. For the physician in private practice (and 60% of psychiatrists are now in that category), to spare time for non-income producing effort is a deterrent. Therefore, he is inclined to project his own frustration as criticism of the psychologist for the luxurious opportunity that tradition has decreed a fair percentage of time spent in research. My own opinion is that this is understandable but unreasonable and can be altered only by the clearer understanding of the point of view of both groups.

As a result of their training, the clinical psychologists are well oriented in various types of research work but their training places an emphasis on basic research. Some of them are inclined to develop undue skepticism regarding knowledge gained from clinical sources. This in turn is related to the attitudes of some psychologists, approaching condescension and belittlement, toward psychiatric knowledge and theory. Anyone who accepts what we now generally refer to as dynamic psychiatry recognizes that there are

many weaknesses in the theory and shortcomings in our knowledge. On the other hand, our body of knowledge has been gained from long experience and at least it is not so removed from human reality as are many of the products of the experimental laboratory. The clinicians cannot solve all the problems or answer all the questions through their own efforts on the wards. The researchers are equally incorrect if they assume that they can find the answer to all the problems in the experimental laboratory.

Since research methods are an important aspect of the training of the clinical psychologist, many of us hope that great advances of knowledge in the field of psychopathology will be forthcoming from this group. There can be no argument that we are sorely lacking in "tested knowledge" regarding mental health and ill health. The statement from the Committee on Psychology of the Group for Advancement of Psychiatry pointed out several fruitful areas for both collaborative and independent research, including diagnostic devices, personality structure, delineation of syndromes, physiological relationships and therapy. To carry on such research, it is essential that the clinical psychologist have training in psychodynamics and therapy. A joint problem of all of us concerned with research in mental ill health is our lack of personnel and financial assistance. The National Mental Health Act has, through the United States Public Health Service, provided a beginning in the problem of finance, but it is still a drop in the bucket compared to the need.

A minor criticism of current research applies to both psychology and psychiatry. So much effort of both is concerned with the pathological when the need is so great for the techniques of prevention. Using all of our clinical resources at the present time we fall far short of meeting the needs for diagnosis and treatment in the field of mental ill health. Even if our personnel were doubled, there is good reason to doubt that we could provide treatment for all those who requested it. The great majority of psychiatrists and clinical psychologists are currently devoting their full time to these fields with the result that minimal consideration is given to the epidemiology of mental ill health and to potential methods for its prevention. Before much progress can be made, extensive research must be carried out.

The profession of psychology, so largely centered in our colleges and universities, could perform an enormously valuable service to the mental health of our nation. The great majority of college students are exposed to one or more courses in psychology. Were these exposures tempered by a teacher with a therapeutic rather than academic attitude, they could provide an incalculable benefit in presenting psychology as a very important tool for the individual to use in living and getting along with people. This would require a method of providing students with opportunities for active learning rather than purely passive formal study. Such courses would

emphasize the motivation of behavior rather than the traditional content. The psychologists—most of whom are members of this Association—should certainly be the ones to experiment in their own courses with techniques for making college education truly meaningful for more effective living.

Summary

Within the present generation, psychiatry and clinical psychology have developed a surprisingly well integrated union. Many of us in both of these professions are convinced that each makes an indispensable contribution to the body of knowledge of the other. It is surprising that such a close and harmonious working relationship could have developed so rapidly. We must agree, however, that we still have much to learn from and about each other. It will mean some modifications in our practice, some changes in our attitudes and a broadening of our mutual experience. To accomplish these, the virtue that we shall need most of all is patience.

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"All that has been said about the difficulty of differential diagnosis and the uncertainty in forming an opinion of physical symptoms is correct. These things necessitate medical knowledge or medical intervention. But the number of cases in which such doubts do not arise at all, and a physician is unnecessary, is surely incomparably greater. From the scientific point of view these cases may be very uninteresting; in life they play a sufficiently important part to justify the work of lay analysts, who are perfectly competent to deal with them. Some time ago I analysed a colleague who displayed a peculiarly strong dislike of the idea that anyone who was not himself a physician should treat patients. I took the opportunity to say to him: 'We have now been working for more than three months. At what point in the analysis have I had occasion to use my medical knowledge?' He admitted that there had been no occasion for it."

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A CHAPLAIN LOOKS AT PSYCHIATRY*

By ROBERT A. PRESTON†

Early in his time of affliction Job cried out:

> "What is my strength, that I should hope,
> And what is mine end, that I should prolong my life?"

This double question is echoed countless times today by troubled people. One might say, in an age of specialization, that the first line belongs to the realm of the psychiatrist: what is the individual's strength; what are his personality assets for enduring the stresses of life? The second line asks about the meaning and destiny of life and therefore is referred to the clergy. Distressed people, however, are not likely to pause in the depths of their misery for the purpose of working out this neat distinction. They want help "all over." Their needs oblige psychiatrists and religionists to come to understand each other and work together.

Most of the writings which have endeavored to bring harmony between the forces of religion and psychiatry have emphasized three mutual concerns: the alleviation of present suffering, the turning of past liabilities into assets, and the prevention of avoidable problems in the future. It is not hard to outline the goals of cooperation. Religious leaders and psychiatrists agree on the desirability of helping people. Also, representatives of each field are eager to have the cooperation of the other. Nevertheless, strong disagreements have existed for a long time. These have centered about academic issues, such as the nature of man, or jurisdictional disputes, *e. g.* whether people need therapy or salvation. Some of these conflicts have stimulated progress in the clearer definition of concepts; many have been pointless and have done damage to patients and parishioners. How can the differences of outlook between psychiatrists and religious exponents be reconciled without destructive concomitants? How may the areas of common interest be enlarged? These questions may be considered as they appear in two kinds of situations: first in the community at large, and second in the clinical setting.

The kind of problem which arises in the community is illustrated by an experience I had several years ago while seeking support for a new mental

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hygiene program. I approached a fellow minister whose congregation included some key people in the city. As soon as psychiatry was mentioned he said, "I don't trust psychiatrists. They are amoral. I once had a fine couple in my church. The husband thought there was something the matter with him and went to a psychiatrist. Soon the wife began consulting the same man. Before I realized what was going on they were getting a divorce. In spite of all I could do they went through with it. Both of them dropped out of the church. I am not willing to lend my support to your program . . ." I found that he knew little about the personal complaints of the couple and nothing significant about the psychiatrist. His generalization about all psychiatrists was an exact parallel to many other generalizations which are made in situations of deep prejudice.

A few months earlier I had heard a psychiatrist theorize somewhat like this: "In my practice I have seen fewer psychotic ministers, proportionately, than members of other professions. Why? Probably because the ministry is a psychosis in itself. Any man who claims to be the mouthpiece of God can be readily diagnosed. But when a church agrees with his delusion, he is sitting pretty." (Note: the minister mentioned above was never converted to a better point of view; the psychiatrist was.)

These two examples are extremes. I believe that they did not represent a norm of psychiatric or clerical attitudes at the time, and that they are even farther from the norm today, but they show what can develop in the community. Religion centers in the church; psychiatry is at work in private practice or in confidential agencies. Between these foci is a wide gulf where misconceptions may grow. Busy people in each field often neglect to bridge the gulf—they find many reasons not to seek out a member of the other profession to get to know him and what he is trying to accomplish. Three devices can improve matters here: literature, conferences, and the personal efforts of individuals. These are most effective if directed toward genuine acquaintance and collaboration in local projects of mutual significance.

Where sincere efforts have been made toward better relations between psychiatry and religion in the community, the results have been gratifying. Many such efforts have developed out of clinical observations in which religious values and psychiatric considerations were found to be inseparably blended. Let us turn, then, to the clinical setting, the second type of situation in which psychiatry and religion meet.

In hospitals which have full-time chaplain service, the relationship between religious representatives and members of the psychiatric professions is obviously much more intimate than in the community. As staff associates they penetrate professional façades and get to know each other as people. They deal with the same living data in their work, for here parish and practice coincide. They compare the relative perspectives of health

and goodness, not only for the specific patient but also for the social groups involved in his future. They share in the mutual successes and frustrations of treatment programs.

A hospital chaplain learns that generalizations about psychiatrists are unreliable. He becomes aroused when he hears someone say that psychiatrists are anti-religious because he knows many who are deeply religious. He also knows many who criticize a certain approach of religion on the basis of ineptitude; these, for example, point out a patient whose religious training was accompanied by severity too great for his sensitive nature to bear, with a resulting incapacity which defeats the more basic purposes of religion. It is easy for a criticism of this kind to be misconstrued by an aggressive religionist, or by a sensation-peddling journalist.

Once in a while a chaplain meets a psychiatrist who expresses opposition to organized religion in general. My own discussions with members of this small minority indicate that there are two principal sources for such an attitude. The psychiatrist has had painful experiences in his own religious history, and he has observed that members of religious groups fall short of the humanitarian goals of their own faith. An undefensive, objective religious appraisal of this situation reveals that even this psychiatrist is not an enemy of religion. In the first place, he is trying to combat the poor methods which were used on him. In the second place, he is employing a very high standard of human welfare values when he criticizes the inconsistency of religious adherents. Religious leaders criticize the same inconsistency, calling it lukewarmness, indifference, or hypocrisy. The standards by which the psychiatrist is making his judgment in this instance are standards which have a religious ancestry. One of the central aims of religion is to develop in people the ability to make value judgments of a high type. One who has gained this ability and is using it in the service of people may be likened to Abou ben Adhem. In spite of opinions about organized religion, it is usually possible for a psychiatrist who feels this way and a chaplain to form a good working relationship and a personal friendship.

Personal acquaintance removes many barriers between the psychiatrist and the minister, but something else is necessary to add broader mutual understanding: namely, the experience of looking at the same set of facts. Only in the clinical setting can this be fully realized. As the chaplain learns more about patients he discovers the real basis for a lot of psychiatric opinions about religion. He finds that many patients have tried religious solutions during the onset of their illness but were unsuccessful. Conventional religious resources did not suffice in these instances. Only skilled diagnosis and treatment could answer the needs at the time. Under treatment, many patients relinquish superficial or immature religious attitudes and are enabled to develop more genuine and practicable expressions of

religion. Moreover, the chaplain may gain a new appreciation of the depth and significance of certain beliefs and practices as he learns more about the dynamics of personality. Sometimes he may see a psychiatrist show greater respect for the tenacity of a religious attitude than would be shown by the average religious leader of an opposing theological position.

Still further understanding is developed between the psychiatrist and the minister as each learns more about techniques of the other. A small slice of psychotherapy taken out of context can be made to look ridiculous. The same is true of isolated religious precepts. When working along with a psychiatrist, a chaplain will see the total perspective and goal of therapy.

On the basis, then, of personal acquaintance, working with the same people, and observing each other's methods and goals, I believe that representatives of psychiatry and religion can come to a real, cooperative, mutual understanding only through shared clinical experience. To make this possible, psychiatrists can give opportunity in hospitals for the expansion of the clinical pastoral training movement. The churches likewise can do more to offer the clinical facilities of their own hospitals to students of psychiatry and to students of religion than they have done in the past. Theological education needs further awakening to the possibilities afforded by clinical experience. All of these developments seem to be moving, but slowly, in a promising direction.

In looking at psychiatry, a chaplain can scarcely avoid analyzing the philosophical assumptions of psychiatrists, trying to discern what they implicitly believe as revealed by their daily work. Dr. Karl Menninger asked me some time ago to jot down a few observations along this line. Accordingly, I wrote the following, expressing what I think psychiatrists believe, whether they put it in words or not:

"You psychiatrists believe that some people can be understood, and by understanding be helped. Behind this belief there is a belief that many people need help. The facts justify these beliefs. Furthermore, you believe that in re-examining your efforts constantly in the light of the results obtained you can discover and affirm a principle of workability. You have concluded that long term results are more important than immediate results. This brings you into the field of social relationships which I shall mention further in a moment.

"You have a belief in the importance and the dignity of the individual human being. It is an assumption, of course, which you make with a dedicated faith, that every individual is worth helping. You believe that each individual has capacities for being destructive, and capacities for being constructive and creative. You feel that it is possible for other human beings like yourselves, granted an understanding of the particular problems or mechanisms of this individual, to guide him in the direction of constructiveness

and away from destructiveness. You have demonstrated that it is possible to strengthen the beneficial positive factors in a severe conflict and to restore people to an inner equilibrium. This requires a disciplined honesty in seeking the real sources of trouble, and implies that health demands truthfulness within the self.

"Concerning society you believe that human beings are interdependent, more deeply and crucially than most people realize. The measure of an individual's health is linked in your concept with his level of usefulness in carrying his own responsibilities and contributing to the welfare of others. Hence, you contend, tendencies which are harmful to others are a mark of disorder within the person and arouse your feeling of responsibility for the use of techniques of modification.

"You are more keenly aware than most people of the influence of groups upon the individual because you see in the mental hospital the persons who have been broken by, or at least not helped by, social institutions—domestic, economic, educational, and religious. You sometimes observe that the teaching of religion has affected individuals in ways which were not intended by the teacher or by the religious leader. Surrounded by the extremes of tragedy, dwelling with the victims of disillusionment and self-destructiveness, you are constantly impressed with the deceptiveness of superficial words and superficial explanations. It leads you to a feeling that there may be praise with the lips while the heart is far away, and hence, that if 'faith is the substance of things hoped for, the evidence of things not seen,' it must be as substantial as possible."

REPORT OF AN EXPERIMENT IN PSYCHIATRIC AIDE TRAINING*

By TIRZAH M. MORGAN, R.N.† and BERNARD H. HALL, M.D.‡

World War II made alarmingly apparent the shortage of medical and nursing personnel trained in neuropsychiatry. This critical shortage gave impetus to increasing interest in the psychiatric education of physicians and nurses.

A large share of the care of patients in present-day neuropsychiatric hospitals is entrusted to men and women who have had no training in any type of nursing. To effect a change to a dynamic orientation in psychiatry, the old custodial type of mental "asylum" must be replaced by the modern neuropsychiatric hospital which functions in the belief that everything that happens to the patient is part of his treatment. Such a hospital of necessity requires in addition to a staff of graduate nurses, a large number of personnel trained in the care of the mentally ill. These facts present a challenge to nursing education which can not be ignored.

At Winter Veterans Administration Hospital attempts have been made to improve the total care of neuropsychiatric patients by offering training to the men and women employed as psychiatric aides. A number of lessons have been learned. This is the report of one of our first attempts at aide education made early in 1947.

Winter VA Hospital is a general hospital in which two-thirds of the beds are occupied by neuropsychiatric patients. At the time this study was made there were approximately nine hundred people employed in the nursing department in a twenty-four hour period. Twelve per cent of these employees were graduate nurses, eight per cent were senior cadet student nurses and the remaining eighty per cent were aides. A few of the nurses had had basic instruction in psychiatric nursing. A small percentage of the aides had had varied kinds and periods of experience in military or state hospitals. Ten per cent of the aides had over ten semester hours of college work, forty-five per cent were high school graduates, thirty-five per cent

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attended high school but were not graduated and ten per cent had never entered high school.

This report is an evaluation of our first attempt to improve the psychiatric knowledge of aides who were giving so much of the nursing care in this hospital. Our program was offered in addition to the eighty-hour clinical and didactic orientation program which is required before any aide is assigned to any nursing service in this hospital. One problem of the Educational Planning Committee was to select a procedure which would best present the broad outlines of dynamic psychiatry to a large number of men and women with no previous psychiatric training. The Educational Planning Committee was composed of three psychiatrists, one nurse, one aide, one educator and the training director of the personnel department.

The approach selected was to present an organized series of eleven lectures covering the basic principles of psychiatry. The lecturers were selected from a volunteer group of resident physicians in psychiatry. Each lecture was repeated six times a week in order to include all personnel without disrupting nursing service to a crippling degree. Even with this planning the lecture groups were very large and there was some disruption of nursing service. In addition to the weekly lecture each aide attended a group discussion at least one hour a week. These groups, one on each hospital service, met once a week to discuss the lecture material and to relate it to the specific nursing service needs. Resident physicians in psychiatry acted as discussion leaders for the groups.

The eleven basic lectures were outlined to include the following topics:

I. Orientation to Psychiatry

Outline of the plan of the course of instruction. Definition of psychiatry and related terms. Origin and explanation of social attitudes toward mental illness. Clifford Beers and the Mental Hygiene Movement. Mental illness as an exaggeration or perversion of normal behavior.

II. The Psychiatric Aide as Member of the Psychiatric Team

Concept of hospital teamwork. The interrelated functions of the psychiatrist, the psychologist, the social worker, the psychiatric nurse and the aide. Character traits of the aide necessary for working with the mentally sick. The problem of handling confidential material. Personal satisfaction derived from helping other people.

III. Personality

Popular concept of personality contrasted with scientific definition. Discussion of various attempts at classification of personality.

IV. Personality Types

Classification of nine different personality types: feeble-minded personality, schizoid personality, suspicious personality, compulsive personality, personality with mood swings, psychopathic personality, criminal personality, sexually perverse personality.

V. Sexual Deviations
Basic anatomy and physiology of sex. Abnormal sexual habits seen in psychiatric patients.

VI. Psychiatric Syndromes
Reasons for closed-wards. Types of neuropsychiatric patients hospitalized on closed-wards. Definition of psychosis. Definition of neurosis. Types of psychoses.

VII. Psychiatric Syndromes—*Continued*
Types of neuropsychiatric patients hospitalized on open wards.

VIII. Treatment in Psychiatry
History. Types of treatment used. General discussion of psychotherapy. Definition and types of physical medicine. Occupational, recreational and educational therapies.

IX. Treatment in Psychiatry—*Continued*
Emergency treatments in the neuropsychiatric hospital. Shock therapy. Prefrontal lobotomy. Fever therapy. Hypnosis. Mental hygiene.

X. Attitude Therapy
Definition and emphasis of importance of attitudes as used therapeutically in neuropsychiatry. The attitude of active friendliness.

XI. Attitude Therapy—*Continued*
Attitudes of indulgence, passive friendliness, watchfulness, matter-of-factness and kind firmness.

Although this program was established primarily for aides, graduate and cadet nurses were encouraged to attend. Despite the fact that the program was to have been mandatory for aides, attendance dropped from ninety-four per cent during the first week to sixty per cent at the end of the eleven weeks. It is to be noted that during the ninth week reduction in Veterans Administration funds resulted in an inability to pay overtime to those aides who attended classes on an overtime basis. This resulted in an immediate drop from eighty-six per cent to sixty-nine per cent, which was a total of twenty-six per cent drop in attendance.

Upon completion of the basic training course a survey was made in an attempt to evaluate the outcome of this type of training program. Three groups of hospital personnel were interviewed individually and were asked to complete check list questionnaires. The first group included ward physicians, ward charge nurses and aide supervisors, all of whom were in positions to observe the ability of the aide to make practical application of the principles which should have been gained from the program. The second group consisted of the resident physicians who participated in the program as discussion leaders. The third group consisted of those who were most directly concerned, the aides.

The first group indicated improvement in two areas. First, the aides showed increased interest in didactic psychiatry. This increased interest

was manifested in their reading. Rather than *True Detective* and *Western Story*, the aide read with interest such books as Preston's *Psychiatry for the Curious* and Beers' *A Mind that Found Itself*. As a direct outgrowth of the stimulus offered by the course, aides at this hospital established and purchased their own professional library, which now numbers nearly two hundred volumes. This library is financed by weekly voluntary donations from the aides.

The second improvement to be seen was an increased interest in patients as sick people. Patient problems had at least academic implications and interest for the aides. However, there was little or no noticeable improvement in aide-patient relationships. Problems which arose from poor psychiatric nursing care of patients were not decreased. For example, the seclusion and accident rate was not reduced. The facts above would indicate that the teaching program was more successful in giving the aide a body of academic psychiatric knowledge than it was in teaching the practical application of psychiatric and of nursing principles.

The discussion group leaders felt that the small discussion groups were of greater interest than the larger lecture groups. In these small groups, specific patient problems which might be distressing to the aide could be discussed and understood. The attitudes, which are a form of prescribed therapy at this hospital, were more clearly defined when they could be related to known patient situations. The most pertinent and most discussed areas were those directly concerned with the personnel-patient relationships, psychiatric concepts and specific prescribed treatments. However, about twenty per cent of the discussion leaders did not feel that even these areas could be discussed profitably. A few of the discussion leaders felt that the main function of these discussion groups was to air personnel problems and complaints. Some felt that this project was too time consuming for the results which were obtained. On the whole, it was felt that most aides did not have the feeling of security which makes it possible for them to participate freely in discussion groups with professional personnel.

Reactions of the aides to the total program were considered most valuable. On the whole they felt that the level of the lectures was too advanced; terms used by most lecturers were beyond their comprehension. Many aides stated very definitely that they felt their intellectual knowledge had been advanced, but that they had gained no insight into either their own feelings or those of the patients. The most frequent criticism was that the program failed to relate material to all hospital services, particularly the medical, surgical and psychoneurotic services. A final examination of the material covered by this course of instruction disclosed that very few of the aides were able to respond accurately to questions which tested their ability to transfer knowledge from one situation to another. Also, they were unable

to apply psychiatric principles to specific patient situations. The consensus was that the discussion groups were more helpful than the lectures but that they, too, often failed to meet the needs of the aide. The aides also felt that because of the large number of lecturers there was not adequate integration of the lectures and that too much material was included in the lectures offered.

Discussion

In attempting to determine the features of this experiment in psychiatric education which were worthwhile to carry on in our next course, and those which were of negative value, we reached several conclusions. A review of similar courses being offered in other hospitals would indicate that they, too, are in danger of pitfalls which were made apparent by this study.

The graduate nurse working in the neuropsychiatric hospital has completed at least three years of professional training as a result of a personal interest in human suffering. This is in contrast to the aide who may seek employment in the neuropsychiatric hospital because he can find no other job or because it appears to be "easy work." This attitude became apparent in such an educational attempt as this represents. When aides had to attend lectures on their own time without benefit of financial remuneration the attendance to lectures immediately dropped twenty-six per cent. As educators we can not make promises of increased pay envelopes or improved status, but we can show that there are worthwhile personal satisfactions to be derived from nursing which are beyond economic values. Many an aide will relate the thrill which is his when a catatonic patient, as a result of the aide's continued efforts, speaks to him after having been mute for many months. The care of the mentally ill can offer such satisfactions to those who desire instruction. These observations would indicate that further attempts at education of aides should center around a selected group who manifest an interest that is not based on financial return but rather on personal satisfaction derived from being able to give better nursing care to the mentally sick.

The Civil Service requirements for the employment of aides in Veteran Administration Hospitals are minimal. Nearly half of the aides employed in this hospital have not been graduated from high school. Such limitations of the educational level of the aide group handicaps any attempts at formal nursing education. The limitation in education was particularly apparent in this experiment in which lectures were given to a group not trained to profit from such instruction. Any attempts at teaching psychiatric nursing to aides should be adapted to the educational level of the students.

Educators have long been aware that learning could not take place unless the needs of the student group were considered and met. Formal instruction

which is planned along lines which a committee decides to be what the group needs may have little or no value. An attempt should be made to interpret the needs of the student group by personal interviews and survey questionnaires before any formal instruction is planned. It would appear that those aides who are actually interested in further instruction would prefer to know more about the specific patient situations in which they are employed and how to manage these situations. This study indicates that attempts to teach neuropsychiatric nursing to aides are most beneficial if directed to small groups in the ward setting in which the aide is employed.

The nosological confusion which exists in present-day neuropsychiatry presents a problem to the nursing educator. Presenting a useful vocabulary of psychiatric terms is, to say the least, difficult.

Selection of teachers presents a real problem. Most medically trained men are not trained in the methods and techniques of teaching. To teach well, and with understanding of the needs of students, requires experience and insight. Frequently those physicians who are the most capable teachers are also the most capable psychiatrists. These men who are capable and who are willing to teach find that the demands of their patients leave little time for instruction of personnel. Those instructors in this experiment who held the interest of the group were those who spent many hours preparing their lectures and in considering the needs of the group.

Since the keynote of any psychiatric therapy is inter-personal relationships, and the aide has more personal contact with the patient than any other member of the therapeutic team, the aide-patient relationship becomes of great importance to the therapist. This educational attempt failed to provide the aide with significant insight into aide-patient relationships. This experiment would indicate that such interpretations can best be given in the specific working situation of the aide. This accounts in part for the increased popularity of the discussion groups as compared to the lectures.

The most significant thing we can offer in psychiatric education is an understanding of inter-personal relationships. Such understanding can give an individual a new and happier outlook on life. As one aide expressed it, "Since I have been to classes and worked here, I understand my folks at home better." This is a real and tangible value which psychiatric nursing has to offer and which to a certain extent is unique in this field of nursing. Nursing educators have a real opportunity to make a significant contribution to the mental hygiene of our professional group and our community.

EXPANDED RESIDENCY PROGRAM IN TOPEKA, KANSAS

The Topeka State Hospital has been added to the clinical facilities available for training residents enrolled in the Menninger Foundation School of Psychiatry. This state hospital is now an integral part of the training program which includes residencies at Winter VA Hospital and the Menninger Sanitarium, approved by the Council on Medical Education and Hospitals of the AMA and by the American Board of Neurology and Psychiatry.

The integrated psychiatric training program in Topeka is a cooperative enterprise directed by the Menninger Clinic with participation by the University of Kansas School of Medicine, the Veterans Administration, the Topeka Psychoanalytic Institute, the Department of Psychology of the University of Kansas, the Schools of Nursing and Social Work of the University of Pittsburgh, Smith College, Washington University and other institutions. Addition of the State Hospital's 1500 beds will make possible an increase in the number of psychiatrists, clinical psychologists, psychiatric social workers, nurses, aides and therapists who can be given training in Topeka.

The immediate increase in the number of Fellows to be admitted to the Menninger Foundation School of Psychiatry is 4; an additional eight will be accepted for July 1, 1950.

Inclusion of the State Hospital in the Topeka training program has been made possible by several recent events, especially the increase in state appropriations for the hospital, the official designation of the hospital as a teaching center with an appropriation of one million dollars for two years, the appointment of Dr. L. P. Ristine as the new superintendent, and the establishment of a Committee on Education for the hospital composed of Dr. Franklin P. Murphy, Dean of the University of Kansas School of Medicine, and Dr. Karl Menninger, Director of Education at the Menninger Clinic.

Dr. John M. Anderson, formerly a Fellow in the Menninger Foundation School of Psychiatry, has been appointed Clinical Director with full responsibility for the medical program. A staff of qualified teaching consultants in psychiatry, neurology, neurosurgery, internal medicine, orthopedics, and other specialties is being appointed.

Topeka is a residential city of 100,000 inhabitants, with available housing at reasonable prices, an excellent school system (including a municipal university), and superior rail and air transportation facilities. The hospital is located within one mile of the Menninger Clinic and the Southard School.

Address requests for information or application blanks to the Committee on Education, Topeka State Hospital, Topeka, Kansas (Attention Dr. Karl Menninger).

BOOK NOTICES

The World Next Door. By FRITZ PETERS. Price $3.00. Pp. 362. New York, Farrar Straus and Company, 1949.

This extraordinary account of the train of thought and corresponding interpretation and misinterpretation of the environment of a disturbed schizophrenic veteran should be required reading for every psychiatrist, every psychiatric nurse, every psychiatric aide. Nothing that has ever appeared, to the reviewer's knowledge, gives so accurate and realistic a portrayal of the schizophrenic process and the difficulties (and benefits) of the hospital experience for such patients. (Karl Menninger, M.D.)

The Marriage Handbook. By JUDSON T. LANDIS and MARY G. LANDIS. Price $3.50. Pp. 513. New York, Prentice-Hall, Inc., 1948.

Factual information about dating, courtship, and marriage is contained in this book and it is identical with *Building a Successful Marriage*, a college text by the same authors. A good many of the standard studies are quoted from, and a good reference list is given at the end of the book. The content is sociological and statistical but presents nothing especially useful to the psychiatrist or clinical psychologist. (Robert G. Foster, Ph.D.)

The Analysis and Control of Human Experience. By PAUL MASLOW. Vol. I, 1946, pp. 195, Vol. II, 1947, pp. 229. Brooklyn, Paul Maslow.

The author presents in a somewhat disconnected manner his speculations, theories and personal insights into a multiplicity of themes. Presumably, the thread which ties together these fields of interest is the Rorschach Test. Reasons for presenting his speculations as being directly derived from Rorschach Test responses are obscure, for no effort is made to give substance to his many elaborations in terms of accepted scientific practice. Little of the material he presents can be accepted without reservation and its value, if any, lies in the occasional insight into human conduct which his rambling outpourings permit. (John W. Chotlos, M.D.)

Readings in the History of Psychology. By WAYNE DENNIS. Price $4.75. Pp. 587. New York, F. S. Crofts, 1948.

This collection of original classics provides a valuable supplement to courses in the history of psychology despite what seems a heavy emphasis on a narrow definition of the field. Over one third of the papers are in the areas of sensation, perception and measurement. Pre-experimental psychology and traditional topics make up the remainder of the volume. Although its chronological span runs from Aristotle to Hull, Freud failed to make the Table of Contents. (Helen Sargent, Ph.D.)

Action Counseling and Process Analysis. By ROBERT B. HAAS. Price $2.00. Pp. 32. New York, Beacon House, 1948.

This paper presents the very familiar psychodramatic and role playing procedure as it is applied to counseling of a young boy pupil by his teacher. It provides an interesting case illustration of the recording of the session with some techniques for analysis. The psychodramatic approach is pre-

sented "as the most positive form of democratic counseling so far in use—a matrix for directive, non-directive or indirective methods, and as an organized approach to a totally 'self directive' counseling process." (Bernard D. Steinzor, Ph.D.)

Medicine in the Changing Order. Report of the New York Academy of Medicine Committee on Medicine and the Changing Order. Price $2.00. Pp. 240. New York, The Commonwealth Fund, 1947.

This report by laymen and experts in medicine, dentistry and nursing, deals with medicine as a part of the total pattern of life as it exists today and its associated economic problems. Suggestions to remedy deficiencies of medical care in urban and rural areas are made and the section on public health is of much interest. Although this book may be read with a feeling of pride and achievement by some, it is apt to make uncomfortable those nurses, dentists and physicians who are inclined to feel that they have no public responsibility. (Ralph W. Coltharp, M.D.)

Successful Marriage: A Modern Guide to Love, Sex and Family Life. By Morris Fishbein and Ernest W. Burgess, eds. Price $6.00. Pp. 547. Garden City, Doubleday & Co., 1947.

The content of the contributions to this volume dealing with sex and reproduction are excellent. It is a misnomer to call it a book on successful marriage unless one holds that sex is the major factor in marriage success. The few chapters that do not treat of some aspect of sex and reproduction are good, but the book lacks balance for a volume that purports to treat the entire field of what constitutes successful marriage. (Robert G. Foster, Ph.D.)

The Psychological Origin and Treatment of Enuresis. By Stevenson Smith. Price $1.75. Pp. 70. Seattle, University of Washington Press, 1948.

The author alleges that this book represents a "practical discussion of bed-wetting." It is debatable whether or not his suggested methods for the "direct conditioning" treatment of enuresis are practical. The recommended ringing bells, streams of cold water and snapping bits of rubber inner tube probably accomplish symptomatic recovery, but using symptomatic therapy before an attempt has been made to study and treat the etiology of the symptom is the antithesis of good medical therapeutics. (Bernard H. Hall, M.D.)

Development of the Basic Rorschach Score with Manual of Directions. By Charlotte Buhler, Karl Buhler, and D. Welty Lefever. Price, $4.20. Pp. 190. Los Angeles, Rorschach Standardization Studies, 1948.

This is a systematic survey of the Rorschach both as a psychological test and a clinical tool. The authors undertook the difficult task of statistical quantification for the many Rorschach variables as they occur in known groups, trying at the same time to retain flexibility of the diagnostic process and global Rorschach interpretation. The study does not validate Rorschach dimensions or functions per se, but repeats the usual postulation of a rationale (largely psychoanalytic) to account for massing of high and low signs in four delineated levels of ego-integration: "adequacy," "conflict,"

"defect," "reality loss." The content and treatment in the present study are geared to the understanding of the more experienced Rorschacher. (Walter Kass)

Conditioned Environment in Casework Treatment. A Monograph of Articles on Hawthorne-Cedar Knolls School and Lavanburg Corner House. New York, Jewish Board of Guardians, 1944.

This monograph, written by social workers on the staff of the Jewish Board of Guardians, offers a critical examination of the treatment program for disturbed children in two institutions under jurisdiction of The Jewish Board of Guardians, a clinically oriented social agency for the treatment of maladjusted children. For those concerned with the therapeutic use of environment in the total treatment of maladjusted individuals, this monograph offers material, rooted in concrete professional experience, of considerable interest. (Edith Beck)

Dementia Praecox. By LEOPOLD BELLAK. Price $10.00. Pp. 456. New York, Grune & Stratton, 1948.

The heroic task of reviewing a 3,200 item bibliography results in a valuable and surprisingly readable guide to the dementia praecox literature, 1936–1946. Twenty chapter headings range from vital statistics to childhood schizophrenia. Approximately half the pages (210) concern therapy of which 170 present shock treatment and 34 miscellaneous treatments. Only 6 pages are needed to discuss psychotherapy (2½ pages dispose of prevention!). The author concludes, "usually, research is the by-product of busy clinicians . . . who try their best but cannot help doing studies in a somewhat hit-or-miss fashion." He offers suggestions for improving the quality of future studies. (Herbert C. Modlin, M.D.)

Personality of the Pre-School Child. By WERNER WOLFF. Price, $5.00. Pp. 341. New York, Grune & Stratton, 1946.

One feels that Doctor Wolff has selected rather arbitrarily from various psychological schools just those theoretical concepts which, taken by themselves, will not interfere with his own very positive views. The wide range of observational and experimental material presented is essentially a set of variations on two basic themes: That all expressions of personality by the young child represent the child's search for his self, and that one must ever keep in mind how different the world of the child is from that of the adult. The best of Piaget, Claparede, and Heinz Werner is packed into this volume. (Edwin S. Kessler, M.D.)

The Common Sense Psychiatry of Dr. Adolf Meyer. By ALFRED LIEF. Price $6.50. Pp. 677. New York, McGraw-Hill Book Co. Inc., 1948.

This documented outline of the life of a great American leader in psychiatry from his earliest work in the Kankakee State Hospital, 1893, through the years in Worcester and New York City to Baltimore, fills a great need. It records the development of Doctor Meyer's life and thinking, and it presents his important contributions in a convenient, orderly assembled form. His emphasis upon humane, medical care of the psychotic, upon the importance of psychology in psychiatry, then upon the psychology

of schizophrenia, the concept of reaction types rather than diseases, the mental hygiene movement, the teaching of psychiatry to young doctors, and finally upon the importance of the holistic point of view—for which he coined the term "psycho-biology—these emphases, as he made them, are here presented in his own words in a volume that succeeding generations of psychiatrists will turn to gratefully. (Karl Menninger, M.D.)

Man and His Works. By MELVILLE J. HERSKOVITS. Price $6.75. Pp. 678. New York, Alfred A. Knopf, 1948.

A remarkable synthesis of the anthropological study of man. Of particular interest to psychiatrists are chapters on Culture and the Individual, Folklore, and A Theory of Culture. This latter chapter gives a splendid discussion of how culture is learned, structured, and contributes to creative expression. The great value of the book lies in its not being a study of a particular culture nor a formal text, but rather an integration of material around the thesis, Man and His Work. (Robert Foster, Ph.D.)

Short Term Therapy in an Authoritative Setting. By BERTRAM M. BECK. Price $1.25. Pp. 112. New York, Family Service Ass'n. of America, 1946.

This is a comprehensive, clear presentation of the operation of a military mental hygiene clinic with a sound and dynamic analysis of military, administrative, and treatment factors. In this setting, social workers with considerable training and experience were called upon to practice short-term therapy under the supervision of psychiatrists. This was justifiable not only because of military urgency but because of the necessity primarily of focusing on the disturbed soldier's situational or environmental problems —and this focus has been and is the area of social work help. I particularly like the author's positive identification with and use of Army authoritative aspects in treatment and the inclusion of rich illustrative case material. (Arthur L. Leader)

Hypnotism Comes of Age. By BERNARD WOLFE and RAYMOND ROSENTHAL. Price $3.00. Pp. 272. New York, The Bobbs-Merrill Company, 1948.

The professional reader will discover a tendency toward a mechanical treatment of psychoanalytic concepts, as is so often seen in the writings of authors who use someone else's ideas. Nevertheless, the presentation is generally quite sober and sound and would be interesting and profitable reading for the sophisticated lay reader, and for the professional person who is looking for a condensed version of hypnosis rather than extensive primary source material. (Gerald A. Ehrenreich)

Take Off Your Mask. By LUDWIG EIDELBERG, M.D. Price $3.25. Pp. 230. New York, International Universities Press, 1948.

For those who would like to know what goes on in an analyst's office and who may not be able to find out by undergoing psychoanalysis, this short book provides an opportunity. It is written somewhat in the form of a novel, and in its eight chapters, separate patients are described as the analyst goes through his working day. The author has been able to describe an analytic session in a way which makes it unusually real and vivid. The

reader is warned in the introduction that unmasking the unconscious is a dangerous operation which should be performed only by a competent person. The reader is admonished not to try it on himself or others, but to keep his mask. He says that this book "is like a toy electric train which, although built on the basis of scientific laws, should not be used for transportation." (Albert R. Owers, M.D.)

A Rorschach Study on the Psychological Characteristics of Alcoholics. By CHARLOTTE BUHLER and D. WELTY LEFEVER. Price $.75. Pp. 64. New Haven, Connecticut, Hillhouse Press, 1948.

In this monograph, the authors attempt to derive a personality description of alcoholics through the use of Rorschach findings. They not only compare the alcoholic group with other clinical groups, but have also broken the alcoholic group down into the same diagnostic categories and compared them with their non-alcoholic counterparts. The weakness of such an approach to the study of personality is suggested by the following comment made by the authors in discussing previous researches of a similar nature: "Even when the same signs are used, however, their evaluation differs." Before this approach can yield fruitful results, a better understanding of what such signs mean in terms of personality must be gained. The larger research which the authors are conducting may further such understanding, rendering the study they present here more meaningful. (Laura Malkenson)

The Creative Nursery Center. By WINIFRED Y. ALLEN and DORIS CAMPBELL. Price $2.75. Pp. 171. New York, Family Service Association of America, 1948.

The Creative Nursery Center is a new manual for those interested in the development and operation of group services for preschool children. Throughout their discussion of the practical procedures and standards for nursery centers, the authors express the point of view that in order to meet the needs of young children such services must be thought of as family services and planned in terms of the child's family situation as well as in terms of his individual development. In relation to this point of view the personality development of early childhood is simply described for readers who have not had contact with the literature of psychiatry or dynamic psychology. (Margaret McFarland, M.D.)

The Alcoholic Woman. By BENJAMIN KARPMAN, M.D. Price $3.75. Pp. 241. Washington, D. C., Linacre Press, 1948.

Karpman's three case histories are a unique contribution to the technical literature of alcoholism which has up till now largely ignored the woman patient. The author distinguishes between two groups of alcoholic women—the chaste and the promiscuous, but deals only with the latter type. The method of treatment is not discussed beyond the statement that it was not by orthodox analysis but by a technique which he calls "objective psychotherapy." The theoretical discussion is meager and bibliographical references are all over twenty years old. (Aaron Paley, M.D.)

Which Way Out. By C. P. OBERNDORF. Price $3.25. Pp. 236. New York, International University Press, 1949.

Oberndorf presents in fictional form the setting and dynamics of psycho-

analysis, using synthetic, composite cases blended and derived from his abundant knowledge and rich clinical experience. Uncovering and making understandable the hidden motivations and passions of strange people and their strange thoughts and actions, he dramatically illustrates for the layman the psychiatric approach to many problems of human interrelations. At the same time, his fictional stories reflect the advances made in the field of psychiatric practice during the twentieth century. Although the literary style is none too good, the episodes make absorbing reading. The book represents an honest, helpful, educative effort. (Jerome B. Katz, M.D.)

Crime: Suicide and Social Well-Being in Your State and City. By AUSTIN PORTERFIELD and ROBERT H. TALBERT. Price $2.00. Pp. 121. Ft. Worth, Leo Potishman Foundation, 1948.

The authors have constructed indices of economic welfare, education and culture, living conditions and medical facilities, and have ranked the forty-eight states according to their criteria. The use of such criteria are valuable in that they are tools for arriving at an approximation of conditions throughout the country. The chapter on suicide, suggests that suicide and crime are opposite types of adjustment and the authors conclude that factors of psychology, family, culture and community are so important that suicide, crime, and alcoholism cannot be alleviated without attacking the problem of control through factors in the milieu. (Robert G. Foster, Ph.D.)

The Battle of the Conscience. By EDMUND BERGLER. Price $3.75. Pp. 296. Washington, D. C., Washington Institute of Medicine, 1948.

This volume is an able study aiming at psychoanalytic (not "psychiatric" as the sub-title erroneously suggests) integration of existing knowledge about the aspects in personality usually referred to as the Conscience. A wealth of clinical material is offered as well as challenging discussions pointing to rapid growth and change in psychoanalysis. The therapist in the author did not always encourage the amount of clarity and systematic thinking that is desirable for science. (Rudolf Ekstein, Ph.D.)

The Show of Violence. By FREDRIC WERTHAM. Price $3.00. Pp. 279. New York, Doubleday & Company, 1948–49.

This is a compendium of case histories of the more lurid of New York's "murders" of the past twenty years, seen from the author's vantage point, usually as a psychiatrist for the defense. Incidental to the case histories, which are presented with their psychodynamic implications, the author makes many valid observations on his basic premise that violence has psycho-socio-biologic roots, and that "murder is no mystery." The book, easily read, is intelligible to the non-professional and it is recommended to the psychiatrist as "escape" reading. (Carl M. Epstein, M.D.)

The Case of Rudolf Hess. J. R. REES, ed. Price $3.00. Pp. 224. New York, W. W. Norton & Co., 1948.

One of the many assets of this book consists in the skillful assembling of authentic records and diaries, including Hess' own statement, thus giving solid background to one of the strangest episodes of World War II.

It seems that the pathology of the Nazi leader presents "A Problem in Diagnosis and Forensic Psychiatry." The apparent lack of agreement in diagnosis merely points up that the professional workers looked at the sick criminal of the Nuremberg trials with different purposes in mind. This book presents valuable and stimulating material for the research worker in any of these fields of interest. (Rudolf Ekstein, Ph.D.)

Trends in Social Work. By FRANK U. BRUNO. Price $4.50. Pp. 387. New York, Columbia University Press, 1948.

This is an historical account of the 75 years of life of the National Conference of Social Work. The author has organized his work into three chronological periods; these include summaries of relevant data. The easy fluid style he has adopted and the colorful detail he has included about the Conference founding fathers and some other early leaders are charming qualities of the book. The third chapter "The World in Which the Conference was Born" sets a pattern that many writers might note. The book's limitations are felt particularly in relation to the administrative problem of the National Conference of Social Work. One would like to have known more of its struggles for growth both from within and without. (Lucille Cairns)

Family Casework and Counseling: A Functional Approach. JESSIE TAFT, ed. Price $3.50. Pp. 304. Philadelphia, University of Pennsylvania Press, 1948.

This book recounts the development of functional casework in the private family agency under the aegis of the Pennsylvania School of Social Work. Its purpose is to provide the reader with evidence from case records through which he may decide whether casework in a social agency is a second rate kind of psychotherapy for the poor or a legitimate kind of helping for which a social agency "can take full responsibility without disguise or apology and without psychiatric supervision." Whether or not they deem the evidence compelling, social workers will find this thoughtful book unusually incisive and rewarding. (Richard E. Benson)

Psychosocial Development of Children. By IRENE M. JOSSELYN. Price $1.75. Pp. 134. New York, Family Service Association, 1948.

Doctor Josselyn intended that these collected lectures (presented primarily to social workers) should serve only as a syllabus and not as a text. It may well be a text, for she succeeded in relating psychological factors to social development in sound realistic ways that were free of controversial concepts. With her dynamic background the task became an excellent workable material for any discipline seriously interested in the psychological growth of human beings. The simplified presentation did not depart from the fact that the mechanism of the individual is a part of society. The references are highly recommended. (Manuel Escudero, M.D.)